

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1079

CERTIFICATE OF DEATH

Reg. Dist. No.

01072  
290

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>New York</b> b. COUNTY <b>New York</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>		c. LENGTH OF STAY IN 1b <b>3 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>26 West Street</b>		d. STREET ADDRESS <b>880 St. Nicholas</b>	
3. NAME OF DECEASED (Type or print) First <b>Demetrio</b> Middle <b>Arroyo</b> Last <b>Arroyo</b>		4. DATE OF DEATH Month <b>1</b> Day <b>23</b> Year <b>1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>Col</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Building Supt.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>	
11. BIRTHPLACE (State or foreign country) <b>Juana Diaz Puerto Rico, Usa</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>World 1 19-01-8861</b>	
17. INFORMANT <b>Lucille Arroyo</b>		Address <b>New York</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>431x</b> IMMEDIATE CAUSE (a) <b>Acute Myocarditis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 23</b> , 19 <b>57</b> , to <b>Jan 23</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Jan 23</b> , 19 <b>57</b> , and that death occurred at <b>6A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Hayward T. Wall</b> M.D. <b>633 N. West Easton, Md.</b> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-28-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Pinelawn National Cem</b>	22d. LOCATION (City, town, or county) (State) <b>Farmingdale L.I. N.Y.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James B. Bloch Easton, Md.</b>		24a. RECEIVED BY REGISTRAR DATE <b>JAN 28 1957</b>	24b. REGISTRAR'S SIGNATURE <b>N. H. Lewis</b>

[illegible]

BUREAU V. S.

28 Nov 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1080  
Item 9 FilmG209 1-24-57et  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

Reg. Dist. No.

01073  
290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Easton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>			d. STREET ADDRESS <u>R.D. 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Anthony</u> Middle <u>Ayers</u> Last <u>Ayers</u>			4. DATE OF DEATH Month <u>January</u> Day <u>16</u> Year <u>1957</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/19/176</u>		9. AGE (In years last birthday) <u>80</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Work</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John Ayers</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Charles Trayers (son)</u> Address <u>Easton, Md.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrothorax, bi-lateral</u> <u>177X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma prostate -</u> <u>widespread metastases</u> (c) <u>-</u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>1957</u> , to <u>1957</u> , that I last saw the deceased alive on <u>1957</u> , and that death occurred at <u>4:00 P.M.</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>		M.D. <u>219 S Washington ST</u>		DATE SIGNED <u>17 Jan 57</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		<u>Easton 16, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Coppersville, Cem</u>	
22d. LOCATION (City, town, or county)		(State) <u>Easton Rt. 4, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Blackwell, Easton Md</u>		ADDRESS <u>Easton Md</u>		24a. REC'D BY REGISTRAR DATE <u>1-19-57</u>	
24b. REGISTRAR'S SIGNATURE <u>N. H. Neuker</u>					

JAN 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1081

CERTIFICATE OF DEATH

Reg. Dist. No.

01074

290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>26 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Baynard</u> Last <u>Baynard</u>				4. DATE OF DEATH Month <u>1</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-26-1881</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William Baynard</u>				14. MOTHER'S MAIDEN NAME <u>(Unknown) Bettyman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>				16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>  </u>			
17. INFORMANT <u>Mr. Floyd Baynard</u>				Address <u>216 N. Aurora St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of bladder</u> <u>181X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>				20f. (City or town) (County) (State) <u>  </u>			
21. I certify that I attended the deceased from <u>1-28-1957</u> to <u>1-28-1957</u> that I last saw the deceased alive on <u>1-28-1957</u> , and that death occurred at <u>9:05 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>  </u> DATE SIGNED <u>  </u>							
ACTUAL SIGNATURE <u>B. Cox</u> M.D. <u>Easton Md</u>							
PHYSICIAN'S NAME (Type) <u>  </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 31 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Newman</u>				24a. REC'D BY REGISTRAR DATE <u>3/1/57</u>			
ADDRESS <u>1509 Easton, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>N. H. Newries</u>			





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1082

## CERTIFICATE OF DEATH

Reg. Dist. No.

01075

290

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>1 hr. 55 min.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>RICHARD</u> First Middle Last <u>BLACKWELL</u>				4. DATE OF DEATH Month <u>1</u> - Day <u>4</u> - Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/25/56</u>	
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u>		IF UNDER 24 HRS. Hours <u>10</u> Min. <u>10</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			
13. FATHER'S NAME <u>RICHARD BLACKWELL</u>				14. MOTHER'S MAIDEN NAME <u>VIRGINIA COPPER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>RICHARD BLACKWELL TRAPPE, MD.</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>601X Gastric Hemorrhage</u> DUE TO <u>Hypertension + Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hydronephrosis + hydrocaliculi</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>1 wk</u> <u>6 wks</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1-4</u> , 19 <u>56</u> , to <u>1-4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-4</u> , 19 <u>57</u> , and that death occurred at <u>4:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John E. Bayburt</u>				ADDRESS (Street, city or town, state) <u>205 S. 1st Ave. Easton, Md 21828</u>			
PHYSICIAN'S NAME (Type) <u>John E. Bayburt</u>				DATE SIGNED <u>1-4-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/8/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Richard</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Blackwell</u>				ADDRESS <u>Easton, Md.</u>			
24a. REC'D BY REGISTRAR <u>1/8/57</u>				24b. REGISTRAR'S SIGNATURE <u>N. H. Neenan</u>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF MORTUARY		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL		19. SIGNATURE OF CREMATION		20. SIGNATURE OF OTHER	

BUREAU V. S.

JAN 17 1957

RECEIVED

John C. Jones



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

291

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Michaels</b>		c. LENGTH OF STAY IN 1b <b>35 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Quantico - Rt. 1</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>North St.</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Woolford</b> Middle <b>W.</b> Last <b>Brown</b>				4. DATE OF DEATH Month <b>January</b> Day <b>10</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Col</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/4/78</b>	
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Oyster Packer</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Brown</b>				14. MOTHER'S MAIDEN NAME <b>Esther Wright</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>XXXXXX</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>XXXXXX 217-07-0882</b>		17. INFORMANT Address <b>James Brown, St. Michaels, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACVD</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Louis S. Welty</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Louis S. Welty</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/15/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Weptiquin Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Quantico Rt. 1 Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James B. Dashiell</b>				ADDRESS <b>Easton, Md.</b>			
24a. REC'D BY REGISTRAR <b>FEB 20 1957</b>				24b. REGISTRAR'S SIGNATURE <b>Mrs. R. Seth</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

FEB 20 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1083

## CERTIFICATE OF DEATH

01076

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 W. 11th</u>	
c. LENGTH OF STAY IN TB <u>2 days</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month <u>1</u> Day <u>4</u> Year <u>1957</u>	
3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>Thelma</u> Last <u>Flach</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Aug 22, 1889</u> 9. AGE (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>h.w.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u> 11. BIRTHPLACE (State or foreign country) <u>USA</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm Sinkensham</u>		14. MOTHER'S MAIDEN NAME <u>Marguerite Flischman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>9m Conrad Flach</u> 17. INFORMANT <u>Thelma</u> Address <u>Chesh</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery, Hard Arteries</u> DUE TO (c) <u>Congestive Heart Fail</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 min</u> <u>3 cp</u> <u>6 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour p. m. 19 <u>56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August</u> , 1956, to <u>Sept 4</u> , 1957, that I last saw the deceased alive on <u>Sept 4</u> , 1956, and that death occurred at <u>4:10 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>K. Lane Wroth</u> M.D.		ADDRESS (Street, city or town, state) <u>St. Michaels, Md.</u> DATE SIGNED <u>1-5-57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-7-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stamilton Harrison</u> ADDRESS <u>St Michaels, Md</u>		24a. REC'D BY REGISTRAR <u>DATE 1-7-57</u> 24b. REGISTRAR'S SIGNATURE <u>N.H. Newlin</u>	



TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01077

1084

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>40 Easton</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Life</b>				d. STREET ADDRESS <b>323 South st.</b>			
3. NAME OF DECEASED (Type or print) <b>Maleiah e First Middle Last Gardner</b>				4. DATE OF DEATH <b>7 9 1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Col</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/6/87</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Isaac Gardner</b>				14. MOTHER'S MAIDEN NAME <b>Rachel Dobson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>XXXX</b>		16. SOCIAL SECURITY NO. <b>XXXX</b>		17. INFORMANT <b>Edward Gardner Easton, Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Arteriosclerosis</b> (b) <b>Cardio-Vascular-Renal Disease</b> (c) <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b> <b>Months</b> <b>Years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-1</b> , 19 <b>46</b> , to <b>1-9</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>1-9</b> , 19 <b>57</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>M. F. Buxell</b>		M.D. <b>19 Feb. 1957</b>		ADDRESS (Street, city or town, state) <b>Easton Maryland</b>		DATE SIGNED <b>1-14-57</b>	
PHYSICIAN'S NAME (Type) <b>M. F. Buxell M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/14/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Chapel Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Easton, Md. 14</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James B. Dashiell, Easton Md.</b> ADDRESS				24a. REC'D BY REGISTRAR <b>DATE 1-14-57</b>		24b. REGISTRAR'S SIGNATURE <b>N. Y. D. Newell</b>	



# CERTIFICATE OF DEATH

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Time of death

6. Place of death

7. Cause of death

8. Nature of disease

9. Duration of disease

10. Name of physician

11. Name of funeral director

12. Name of undertaker

13. Name of cemetery

14. Name of burial place

15. Name of interment place

16. Name of crematorium

17. Name of crematorium

18. Name of crematorium

BUREAU V. S.

JAN 17 1957

RECEIVED

1085

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot Green Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>4 1/2 hr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>17x-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Gave</u> Last <u>HANSON</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 6, 1900</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert H. HANNA</u>		14. MOTHER'S MAIDEN NAME <u>Susan Ann Muir</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Mrs. Wade H. Hanson</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mesenteric thrombosis</u> 416x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Advanced Rheumatic Heart Disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>12:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>		ADDRESS (Street, city or town/state) <u>219 S. Washington St. - 24101-57</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		DATE SIGNED <u>Jan 24 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1-26-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Episcopal Church Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>St. Michaels</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		ADDRESS <u>Church Hill</u>	
24a. REC'D BY REGISTRAR <u>1-26-57</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Neenan</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

DATE OF DEATH

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BUREAU V. S.

FEB 4 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO HEALTH DEPARTMENT: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1086

## CERTIFICATE OF DEATH

01079

Reg. Dist. No.

290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON, Md.</u>	c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17x22 Chester</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial</u>		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Rickey</u> Middle <u>John</u> Last <u>Harris</u>		4. DATE OF DEATH Month <u>1</u> Day <u>24</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 4 1956</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>11</u> IF UNDER 1 YEAR Months <u>20</u> Days <u>20</u> Hours <u>20</u> Min. <u>20</u>
10c. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>William Elfred Harris</u>		14. MOTHER'S MAIDEN NAME <u>Maigaret Anderson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>William Elfred Harris, father - Chester, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>hyperpyrexia</u> <u>571.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Dioxin</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. <u>11</u> p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>2:05</u> P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u> M.D.		<u>219 S. Washington St. 24th 57</u>	
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>		<u>Easton 16, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/26/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Stonemansville</u>	22d. LOCATION (City, town, or county) (State) <u>Stonemansville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar E. Lane</u> ADDRESS <u>Church Hill Md.</u>		24a. REC'D BY REGISTRAR DATE <u>1-26-57</u>	24b. REGISTRAR'S SIGNATURE <u>N.H. Neenan</u>

CERTIFICATE OF DEATH

PLACE OF DEATH		DATE OF DEATH	
RESIDENT OF		DECEASED	
DATE OF BIRTH		PLACE OF BIRTH	
MARRIED		SINGLE	
OCCUPATION		CAUSE OF DEATH	
MANNER OF DEATH		MEDICAL HISTORY	
EDUCATION		PREVIOUS ILLNESS	
RELIGION		TREATMENT	
FAMILY HISTORY		LABORATORY TESTS	
SOCIAL HISTORY		POST-MORTEM	
SMOKING		ALCOHOL	
DRUGS		DIET	
EXERCISE		STRESS	
TEMPERATURE		PULSE	
BLOOD PRESSURE		HAEMOGLOBIN	
URINE		STOOL	
SPEECH		HEARING	
VISION		TASTE	
SMELL		TOUCH	
PAIN		ITCHING	
SLEEP		APPETITE	
WEIGHT		HEIGHT	
TEMPERATURE		PULSE	
BLOOD PRESSURE		HAEMOGLOBIN	
URINE		STOOL	
SPEECH		HEARING	
VISION		TASTE	
SMELL		TOUCH	
PAIN		ITCHING	
SLEEP		APPETITE	
WEIGHT		HEIGHT	

RECEIVED  
FEB 4 1957  
BUREAU T. B.



1087

CERTIFICATE OF DEATH

Reg. Dist. No.

01080

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17X-2 Queen Anne's Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>17X-2 Queen Anne's Md</u>	
3. NAME OF DECEASED (Type or print) First <u>Sharon</u> Middle <u>Lee</u> Last <u>Harris</u>		4. DATE OF DEATH Month <u>January</u> Day <u>9</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 31, 1950</u>
9. AGE (In years last birthday) <u>6</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>8</u> Days <u>10</u> Hours <u>11</u> Min. <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Albert Leon Harris</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jacobs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mary Murray (Mother)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Filiform pneumonia</u> 756.2 DUE TO <u>Multiple renal fistulae</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congenital obstructed bile duct</u> DUE TO (c) <u>Congenital obstructed bile duct</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____ to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>6:50 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u>		ADDRESS (Street, city or town, state) <u>219 S.W. 25th Ave. Apt 17 St 17th St 57</u>	
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>		DATE SIGNED <u>1-14-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-14-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Newlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Newton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Schell, Easton, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>1-14-57</u>		24b. REGISTRAR'S SIGNATURE <u>N.H. Newlin</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

010840

1088

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>TALBOT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>40 EASTON</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM ALBERT HARRIS</b>				4. DATE OF DEATH Month Day Year <b>1 3 1957</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>col</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-8-26</b>	
9. AGE (In years last birthday) <b>30 yrs.</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>odd-jobs</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Hutton Harris</b>				14. MOTHER'S MAIDEN NAME <b>Lizzie Jenkins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Co. Birth records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congenital heart defects</b> <b>754.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>sudden death in bed-</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Louis S. Welty</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Louis S. Welty</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>12-4-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>1/5/56</b>		<b>Royal Oak Can</b>		<b>Royal Oak, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James B. B. B.</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>1 4 1957</b>	
						24b. REGISTRAR'S SIGNATURE <b>M. H. Harris</b>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD. 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. S.

JAN 14 1957

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1

INSTRUCTIONS

TO **ENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be completed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO **FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01082

## CERTIFICATE OF DEATH

1098

Reg. Dist. No. 291

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>St. Michaels, Md.</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>St. Michaels, Maryland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rio Vista Nursing Home</u> <u>St. Michaels, Maryland</u>				STREET ADDRESS (If rural give location) <u>1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Alice Sparks Harrison</u>				<b>4. DATE OF DEATH</b> (Month) <u>Jan.</u> (Day) <u>27</u> (Year) <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Apr. 23, 1863</u>	9. AGE last birthday <u>93</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>St. Michaels, Talbot, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oliver P. Sparks</u>				14. MOTHER'S MAIDEN NAME <u>Mary Kemp</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. Harold Bush</u> <u>Detroit, Michigan</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
4221 IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>						<u>10 min</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardiovascular Dis</u>						<u>10 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Paroxysmal Fibrillation</u>						<u>5 yrs</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>26 Nov 56</u> to <u>27 Jan 57</u> , that I last saw the deceased alive on <u>26 Jan 57</u> , 19 <u>57</u> , and that death occurred at <u>3:00 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>R. Lane Wrath</u>		M.D. <u>Box 487</u>		ADDRESS (Street, city, town, state) <u>St. Michaels, Md.</u>		DATE SIGNED <u>1-28-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/29/57</u>		NAME OF CEMETERY OR CREMATORY <u>Olivet Cemetery</u>		LOCATION (City, town, or county) (State) <u>St. Michaels Talbot, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>Jan 29/57</u>		REGISTRAR'S SIGNATURE <u>Mrs. Robert L. Seft</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas D. Marshall</u>		ADDRESS <u>St. Michaels, Md.</u>	



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

FILE NO. 112

NAME: Maryland

AGE: 21

DATE OF DEATH: 1957

PLACE OF DEATH: Baltimore

BUREAU V. 2

FEB 4 1957

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01084

1089

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> & da.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federal's burg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>05X02</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>Harrison</u> Last <u>Haynes</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 5, 1997</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>8</u> Hours <u>15</u> Min.		IF UNDER 24 HRS. Months <u>5</u> Days <u>8</u> Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Henry Haynes</u>				14. MOTHER'S MAIDEN NAME <u>Ella Nichols</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Anna Haynes</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis - R. hemiplegia</u> 260X DUE TO <u>Dialysis nulliter</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary TBE</u> (c) <u>1 year</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>002X</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> (?) <u>1 year</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>1/4</u> , 19 <u>57</u> , to <u>1/12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/12</u> , 19 <u>57</u> , and that death occurred at <u>9:40</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Benjamin Haynes</u>				ADDRESS (Street, city or town, state) <u>Caroline, Maryland</u> DATE SIGNED <u>Jan 57</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>January 15, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Paul Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Federalburg, Md. R.F.D.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frampton</u> ADDRESS <u>Federalburg, Maryland</u>				24a. REC'D BY REGISTRAR <u>1-15-57</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Newell</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]	
3. AGE [REDACTED]		4. DATE OF BIRTH [REDACTED]	
5. PLACE OF BIRTH [REDACTED]		6. OCCUPATION [REDACTED]	
7. MARITAL STATUS [REDACTED]		8. CAUSE OF DEATH [REDACTED]	
9. MANNER OF DEATH [REDACTED]		10. PLACE OF DEATH [REDACTED]	
11. SIGNATURE OF DECEASED [REDACTED]		12. SIGNATURE OF WITNESS [REDACTED]	
13. SIGNATURE OF PHYSICIAN [REDACTED]		14. SIGNATURE OF CLERK [REDACTED]	
15. SIGNATURE OF REGISTRAR [REDACTED]		16. SIGNATURE OF DECEASED [REDACTED]	
17. SIGNATURE OF WITNESS [REDACTED]		18. SIGNATURE OF PHYSICIAN [REDACTED]	
19. SIGNATURE OF CLERK [REDACTED]		20. SIGNATURE OF REGISTRAR [REDACTED]	
21. SIGNATURE OF DECEASED [REDACTED]		22. SIGNATURE OF WITNESS [REDACTED]	
23. SIGNATURE OF PHYSICIAN [REDACTED]		24. SIGNATURE OF CLERK [REDACTED]	
25. SIGNATURE OF REGISTRAR [REDACTED]		26. SIGNATURE OF DECEASED [REDACTED]	
27. SIGNATURE OF WITNESS [REDACTED]		28. SIGNATURE OF PHYSICIAN [REDACTED]	
29. SIGNATURE OF CLERK [REDACTED]		30. SIGNATURE OF REGISTRAR [REDACTED]	
31. SIGNATURE OF DECEASED [REDACTED]		32. SIGNATURE OF WITNESS [REDACTED]	
33. SIGNATURE OF PHYSICIAN [REDACTED]		34. SIGNATURE OF CLERK [REDACTED]	
35. SIGNATURE OF REGISTRAR [REDACTED]		36. SIGNATURE OF DECEASED [REDACTED]	
37. SIGNATURE OF WITNESS [REDACTED]		38. SIGNATURE OF PHYSICIAN [REDACTED]	
39. SIGNATURE OF CLERK [REDACTED]		40. SIGNATURE OF REGISTRAR [REDACTED]	
41. SIGNATURE OF DECEASED [REDACTED]		42. SIGNATURE OF WITNESS [REDACTED]	
43. SIGNATURE OF PHYSICIAN [REDACTED]		44. SIGNATURE OF CLERK [REDACTED]	
45. SIGNATURE OF REGISTRAR [REDACTED]		46. SIGNATURE OF DECEASED [REDACTED]	
47. SIGNATURE OF WITNESS [REDACTED]		48. SIGNATURE OF PHYSICIAN [REDACTED]	
49. SIGNATURE OF CLERK [REDACTED]		50. SIGNATURE OF REGISTRAR [REDACTED]	
51. SIGNATURE OF DECEASED [REDACTED]		52. SIGNATURE OF WITNESS [REDACTED]	
53. SIGNATURE OF PHYSICIAN [REDACTED]		54. SIGNATURE OF CLERK [REDACTED]	
55. SIGNATURE OF REGISTRAR [REDACTED]		56. SIGNATURE OF DECEASED [REDACTED]	
57. SIGNATURE OF WITNESS [REDACTED]		58. SIGNATURE OF PHYSICIAN [REDACTED]	
59. SIGNATURE OF CLERK [REDACTED]		60. SIGNATURE OF REGISTRAR [REDACTED]	
61. SIGNATURE OF DECEASED [REDACTED]		62. SIGNATURE OF WITNESS [REDACTED]	
63. SIGNATURE OF PHYSICIAN [REDACTED]		64. SIGNATURE OF CLERK [REDACTED]	
65. SIGNATURE OF REGISTRAR [REDACTED]		66. SIGNATURE OF DECEASED [REDACTED]	
67. SIGNATURE OF WITNESS [REDACTED]		68. SIGNATURE OF PHYSICIAN [REDACTED]	
69. SIGNATURE OF CLERK [REDACTED]		70. SIGNATURE OF REGISTRAR [REDACTED]	
71. SIGNATURE OF DECEASED [REDACTED]		72. SIGNATURE OF WITNESS [REDACTED]	
73. SIGNATURE OF PHYSICIAN [REDACTED]		74. SIGNATURE OF CLERK [REDACTED]	
75. SIGNATURE OF REGISTRAR [REDACTED]		76. SIGNATURE OF DECEASED [REDACTED]	
77. SIGNATURE OF WITNESS [REDACTED]		78. SIGNATURE OF PHYSICIAN [REDACTED]	
79. SIGNATURE OF CLERK [REDACTED]		80. SIGNATURE OF REGISTRAR [REDACTED]	
81. SIGNATURE OF DECEASED [REDACTED]		82. SIGNATURE OF WITNESS [REDACTED]	
83. SIGNATURE OF PHYSICIAN [REDACTED]		84. SIGNATURE OF CLERK [REDACTED]	
85. SIGNATURE OF REGISTRAR [REDACTED]		86. SIGNATURE OF DECEASED [REDACTED]	
87. SIGNATURE OF WITNESS [REDACTED]		88. SIGNATURE OF PHYSICIAN [REDACTED]	
89. SIGNATURE OF CLERK [REDACTED]		90. SIGNATURE OF REGISTRAR [REDACTED]	
91. SIGNATURE OF DECEASED [REDACTED]		92. SIGNATURE OF WITNESS [REDACTED]	
93. SIGNATURE OF PHYSICIAN [REDACTED]		94. SIGNATURE OF CLERK [REDACTED]	
95. SIGNATURE OF REGISTRAR [REDACTED]		96. SIGNATURE OF DECEASED [REDACTED]	
97. SIGNATURE OF WITNESS [REDACTED]		98. SIGNATURE OF PHYSICIAN [REDACTED]	
99. SIGNATURE OF CLERK [REDACTED]		100. SIGNATURE OF REGISTRAR [REDACTED]	

BUREAU V. S.

JAN 22 1957

RECEIVED



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11,13,14 FilmG210 2-13-57 et

## CERTIFICATE OF DEATH

1090

Item 9 FilmG210 2-15-57 et

01085

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Purchester</u> b. COUNTY <u>Co.</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Humbleton Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>09X02</u>			
3. NAME OF DECEASED (Type or print) <u>Ernest</u> First Middle Last				4. DATE OF DEATH <u>1</u> Month <u>22</u> Day <u>1957</u> Year			
5. SEX <u>m</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Approx.</u>		9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>"Probably Virginia"</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Era Mapp (Daughter)</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1/22</u> , 19 <u>57</u> , to <u>1/22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/22</u> , 19 <u>57</u> , and that death occurred at <u>11:20 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thurston Harrison</u> M.D.				ADDRESS (Street, city or town, state) <u>Catonsville, Maryland</u> DATE SIGNED <u>5 Feb 57</u>			
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>1/25/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		22d. LOCATION City, town, or county (State) <u>East New Market Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John S. Killough</u> ADDRESS <u>East New Market</u>				24a. REC'D BY REGISTRAR DATE <u>1/25/57</u>		24b. REGISTRAR'S SIGNATURE <u>N.H. Newsum</u>	

RECEIVED

FEB 9 1957

BUREAU V. S.

1. DEPARTMENT OF HEALTH		2. COUNTY	
3. CITY		4. STATE	
5. SEX		6. AGE	
7. RACE		8. OCCUPATION	
9. MARITAL STATUS		10. EDUCATION	
11. RELIGION		12. DATE OF BIRTH	
13. DATE OF DEATH		14. PLACE OF DEATH	
15. CAUSE OF DEATH		16. MANNER OF DEATH	
17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF WITNESS	
19. SIGNATURE OF CORONER		20. SIGNATURE OF JURY	
21. SIGNATURE OF DEATH CERTIFICATE		22. SIGNATURE OF DEATH CERTIFICATE	
23. SIGNATURE OF DEATH CERTIFICATE		24. SIGNATURE OF DEATH CERTIFICATE	
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95. SIGNATURE OF DEATH CERTIFICATE		96. SIGNATURE OF DEATH CERTIFICATE	
97. SIGNATURE OF DEATH CERTIFICATE		98. SIGNATURE OF DEATH CERTIFICATE	
99. SIGNATURE OF DEATH CERTIFICATE		100. SIGNATURE OF DEATH CERTIFICATE	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1091

## CERTIFICATE OF DEATH

01086

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
c. LENGTH OF STAY IN 1b <u>4 hrs 5 min</u>		d. STREET ADDRESS <u>11 Trappe</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clayton</u> Middle <u>Le</u> Last <u>Bates</u>		4. DATE OF DEATH Month <u>1</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-3-1888</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>6</u> Days <u>8</u> Hours <u>16</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.A. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isiah Le Bates</u>		14. MOTHER'S MAIDEN NAME <u>George W. Houghby</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs May Le Bates</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive gastro-intestinal hemorrhage</u> <u>540.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Gastrointestinal ulcer</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>3:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u>		DATE SIGNED <u>7:19 P.M. 1-18-57</u>	
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>		ADDRESS (Street, city or town, state) <u>Easton 10, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan 18, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Easton, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Newman &amp; Son</u>		ADDRESS <u>Easton, Md.</u>	
24a. REC'D BY REGISTRAR <u>1-18-57</u>		24b. REGISTRAR'S SIGNATURE <u>N.H. Newview</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN		16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF MORTUARY		18. SIGNATURE OF BURIAL		19. SIGNATURE OF CREMATION		20. SIGNATURE OF OTHER	

BUREAU V. S.

JAN 22 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1092

CERTIFICATE OF DEATH

01087

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>7 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Bell</u> Last <u>Heard</u>				4. DATE OF DEATH Month <u>January</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 7, 1889</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Montgomery</u>				14. MOTHER'S MARRIED NAME <u>Agnes Bell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs Grace Leonard Gault</u> Address <u>Gault</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct 2nd Myocardial</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis.</u> DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ A.M., from the causes and on the date stated above.			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ A.M., from the causes and on the date stated above.				22. ADDRESS (Street, city or town, state) <u>219 S. Washington St. 19 Jan 57</u>			
22. ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.				22. DATE SIGNED <u>19 Jan 57</u>			
22. PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				22. ADDRESS <u>Easton 16, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 21, 1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		23d. LOCATION (City, town, or county) <u>Easton, Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Neenan &amp; Son</u> ADDRESS <u>Easton, Md</u>				24a. REC'D BY REGISTRAR <u>1/21/57</u>		24b. REGISTRAR'S SIGNATURE <u>M. H. Neenan</u>	



RECEIVED  
JAN 22 1957  
BUREAU V. 5

1093

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH o. COUNTY <b>Talbot</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>				c. LENGTH OF STAY IN 1b <b>life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>Dutchman's Lane</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>C.</b> Last <b>MARVEL</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>26,</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 27, 1867</b>	
9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Joseph H. Jones</b>				14. MOTHER'S MAIDEN NAME <b>Sarah M. Warner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Raymond Marvel</b> Address <b>Easton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>332X</b> IMMEDIATE CAUSE (a) <b>Cerebral Vascular Occlusion</b> DUE TO (b) <b>Cerebral Arteriosclerosis.</b> DUE TO (c) <b>Generalized Arteriosclerosis.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>HOURS</b> <b>1 yr.</b> <b>YRS.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Jan 1950</b> to <b>1/26</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>1/26</b> , 19 <b>57</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Easton, Md</b> DATE SIGNED <b>1/28/57</b> ACTUAL SIGNATURE <b>Shepard Krech, Jr.</b> M.D. PHYSICIAN'S NAME (Type) <b>Shepard Krech, Jr.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 29, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Easton, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Newnam &amp; Son</b> ADDRESS <b>Easton, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>1/29/57</b>		24b. REGISTRAR'S SIGNATURE <b>N.A. Neekes</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 291

1100

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>McDaniel</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>McDaniel,</b>	
c. LENGTH OF STAY IN 1b <b>15 years</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>E.</b> Last <b>Mills</b>		4. DATE OF DEATH Month <b>1</b> Day <b>3</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/26/1870</b>
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George W. Kappyx Kelly</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Thompson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Willis Brinsfield, Sr. Eldorado, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> (c) <b>Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b> <b>10 yrs</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1940</b> to <b>1957</b> , that I last saw the deceased alive on <b>Jan 3</b> , 19 <b>57</b> , and that death occurred at <b>12:30</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Guy M Reeser Sr</b>		DATE SIGNED <b>Jan 3 1957</b>	
PHYSICIAN'S NAME (Type) <b>GUY M REESER SR</b>		<b>TILGHMAN MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/6/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Vienna Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Vienna, Dorchester Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard Moore Tilghman Sr</b>		ADDRESS <b>Talbot</b>	
24a. REC'D BY REGISTRAR <b>Jan 7 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mrs. E. H. Kelly</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO REGISTAR DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filled with the registrar's signature and address.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14, Film 6210 2-13-57 et

01090

1094

# CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY in 1b <u>11 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>05021 Denton</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>714 Gay St</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Gertrude</u> Middle <u>Morgan</u> Last <u>Morgan</u>		4. DATE OF DEATH Month <u>January</u> Day <u>26</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 23 1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years full birthday) <u>75</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Augusta Campbell</u>		14. MOTHER'S MAIDEN NAME <u>Francis Wallace</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Roy Horney (daughter)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>434.1 Chronic congestive heart failure</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/15</u> , 19 <u>57</u> , to <u>1/26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/25</u> , 19 <u>57</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thorston Harrison</u>		M.D. <u>Carter, Maryland</u> DATE SIGNED <u>5 Feb 57</u>	
PHYSICIAN'S NAME (Type) <u>THORSTON HARRISON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 29 57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		22d. LOCATION (City, town, or county) (State) <u>Denton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L.V. Moore &amp; Son</u>		ADDRESS <u>Denton Md</u>	
24a. REC'D BY REGISTRAR <u>N.H. Newer</u>		24b. REGISTRAR'S SIGNATURE <u>N.H. Newer</u>	

MEDICAL CERTIFICATION

RECEIVED

FEB 8 1957

BUREAU V. S.

1. DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS		2. STATE OF NEW YORK	
3. COUNTY OF NEW YORK		4. CITY OF NEW YORK	
5. NAME OF DECEASED		6. SEX	
7. DATE OF BIRTH		8. PLACE OF BIRTH	
9. DATE OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF DECEASED	
15. SIGNATURE OF WITNESS		16. SIGNATURE OF DECEASED	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF DECEASED	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF DECEASED	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF DECEASED	
23. SIGNATURE OF DECEASED		24. SIGNATURE OF DECEASED	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF DECEASED	
27. SIGNATURE OF DECEASED		28. SIGNATURE OF DECEASED	
29. SIGNATURE OF DECEASED		30. SIGNATURE OF DECEASED	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF DECEASED	
33. SIGNATURE OF DECEASED		34. SIGNATURE OF DECEASED	
35. SIGNATURE OF DECEASED		36. SIGNATURE OF DECEASED	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF DECEASED	
39. SIGNATURE OF DECEASED		40. SIGNATURE OF DECEASED	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF DECEASED	
43. SIGNATURE OF DECEASED		44. SIGNATURE OF DECEASED	
45. SIGNATURE OF DECEASED		46. SIGNATURE OF DECEASED	
47. SIGNATURE OF DECEASED		48. SIGNATURE OF DECEASED	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF DECEASED	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF DECEASED	
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67. SIGNATURE OF DECEASED		68. SIGNATURE OF DECEASED	
69. SIGNATURE OF DECEASED		70. SIGNATURE OF DECEASED	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF DECEASED	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF DECEASED	
75. SIGNATURE OF DECEASED		76. SIGNATURE OF DECEASED	
77. SIGNATURE OF DECEASED		78. SIGNATURE OF DECEASED	
79. SIGNATURE OF DECEASED		80. SIGNATURE OF DECEASED	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF DECEASED	
83. SIGNATURE OF DECEASED		84. SIGNATURE OF DECEASED	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF DECEASED	
87. SIGNATURE OF DECEASED		88. SIGNATURE OF DECEASED	
89. SIGNATURE OF DECEASED		90. SIGNATURE OF DECEASED	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF DECEASED	
93. SIGNATURE OF DECEASED		94. SIGNATURE OF DECEASED	
95. SIGNATURE OF DECEASED		96. SIGNATURE OF DECEASED	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF DECEASED	
99. SIGNATURE OF DECEASED		100. SIGNATURE OF DECEASED	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG211 3-6-57 et

01091

CERTIFICATE OF DEATH

Reg. Dist. No.

290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO Cordova - Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Munday</u> Last <u>Munday</u>		4. DATE OF DEATH Month <u>January</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Approx. 77</u> yrs.
9. AGE (In years lost birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry Munday</u>		14. MOTHER'S MAIDEN NAME <u>Lizzie Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Marshall Taylor</u> Address <u>Nephew Taylor, Charles Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right Hemiplegia</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebro Vascular Accident</u> DUE TO (c) <u>General Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>3 weeks</u> <u>yes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 29</u> , 19 <u>56</u> , to <u>1-19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-19</u> , 19 <u>57</u> , and that death occurred at <u>5:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. F. Buell</u>		ADDRESS (Street, city or town, state) <u>19 J. Edgar Hoover Bldg. Easton Md</u>	
DATE SIGNED <u>1-20-57</u>			
PHYSICIAN'S NAME (Type) <u>M. F. Buell</u>		<u>Easton Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/23/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Newtown</u>		22d. LOCATION (City, town or county) (State) <u>Cordova Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Washell</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>1/23/57</u>		24b. REGISTRAR'S SIGNATURE <u>M. R. Neer</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

FEB 4 1957

RECEIVED

1. *Chlorophyll a* (Chl a) is the primary photosynthetic pigment in most plants and algae. It is a green pigment that absorbs light energy in the blue-violet and red-orange regions of the visible spectrum. Chl a is essential for the light-dependent reactions of photosynthesis, where it converts light energy into chemical energy.

**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01092

# CERTIFICATE OF DEATH

Reg. Dist. No. **290**

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>TALBOT</b>		MARYLAND		STATE <b>MARYLAND</b>		COUNTY <b>TALBOT</b>	
CITY OR TOWN <b>OXFORD</b>		LENGTH OF STAY (in this place) <b>LIFE</b>		CITY OR TOWN <b>OXFORD</b>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<b>BESSIE E. POPE</b>				<b>JAN. 16, 1957</b>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 24 HRS.</b>		
<b>Female</b>	<b>White</b>	<b>Married</b>	<b>Sept. 20, 1881</b>	<b>75</b> Yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>Housewife</b>		<b>Home</b>		<b>Maryland</b>		<b>U.S.</b>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<b>Algie Crow</b>				<b>Mary Bafford</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
				<b>Mr. Oscar Pope Oxford, Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>420.1 IMMEDIATE CAUSE (A)</b>				<b>Cardiac failure</b>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>				<b>Coronary atherosclerosis</b>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b>				<b>(?)</b>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				<b>(?)</b>			
<b>19a. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>		<b>20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>1 pm</u>, 19<u>57</u>, to <u>16 Jan</u>, 19<u>57</u>, that I last saw the deceased alive on <u>13 Jan</u>, 19<u>57</u>, and that death occurred at <u>16 Jan</u>, 19<u>57</u>, M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS (Street, city, town, state)</b>			
<b>Maurice E. Newnam</b>				<b>16 Jan 57</b>			
<b>M.D.</b>				<b>DATE SIGNED</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<b>Burial</b>		<b>Jan. 19, 1957</b>		<b>Oxford Cemetery</b>		<b>Oxford, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<b>DATE</b>		<b>1/19/57</b>		<b>Maurice E. Newnam &amp; Son</b>		<b>Easton, Md.</b>	





1102

## CERTIFICATE OF DEATH

01093

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton - Rural</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>05x22 Federalsburg</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Easton - Preston Road</b>				d. STREET ADDRESS <b>211 Maple Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Wilmer</b> Middle <b>Thomas</b> Last <b>Rowins</b>				4. DATE OF DEATH Month <b>January</b> Day <b>25</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>July 20, 1883</b>		9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile Agency</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas R. Rowins</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Wright</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-12-5720</b>		17. INFORMANT <b>Mrs. Maude E. Rowins, Federalsburg, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardio Vascular</b> DUE TO (c) <b>Renal disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b> <b>7/10/54</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 10, 1954</b> , to <b>JAN 23, 1956</b> , that I last saw the deceased alive on <b>Jan 23, 1956</b> , and that death occurred at <b>5:30 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. E. Lennon</b> M.D.				ADDRESS (Street, city or town, state) <b>Federalsburg Md</b> DATE SIGNED <b>1-24-56</b>			
PHYSICIAN'S NAME (Type) <b>W. E. Lennon M.D.</b>				<b>Federalsburg, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 26, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hill Crest Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Federalsburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Frampton and Son, Federalsburg, Maryland</b>				ADDRESS <b>Federalsburg, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>1-26-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>N. D. Nevers</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1103

## CERTIFICATE OF DEATH

## 01094

## Reg. Dist. No. 290

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Talbot</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Talbot</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxford.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x 1 Rural Royal Oak, Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Willard</u> Middle <u>Berridge</u> Last <u>Saulsbury</u>				<b>4. DATE OF DEATH</b> Month <u>Jan</u> , <u>12</u> , 57' 19			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 4, 1889</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Tenant Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Talbot County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>			
13. FATHER'S NAME <u>John Thomas Saulsbury</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Burrige</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-30-7816</u>		17. INFORMANT Address <u>Mrs. Harry W. Crosby Oxford, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diffuse Carcinomatosis</u> DUE TO <u>Carcinoma Pancreas</u> (b) <u>157x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/8</u> , 19 <u>56</u> , to <u>1/12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/8</u> , 19 <u>57</u> , and that death occurred at <u>9 P.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>136 S. Washington St</u> DATE SIGNED ACTUAL SIGNATURE <u>J. W. P. Garnett</u> M.D. <u>Easton, Md</u> PHYSICIAN'S NAME (Type) <u>J. H. P. GARNETT, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 15, 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Easton Md</u>				24a. REC'D BY REGISTRAR DATE <u>1-15-57</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

02232  
Reg. Dist. No. 290

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Talbot</u> <span style="float:right">1096</span> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN 1b <u>Six Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Rural - Trappe</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Martin</u> Middle <u>Edward</u> Last <u>Wilson</u>		<b>4. DATE OF DEATH</b> Month <u>Jan.</u> Day <u>30</u> Year <u>19 57</u>									
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Negro</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Dec. 22, 1881</u>								
<b>9. AGE</b> (In years last birthday) <u>75</u> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Months	Days	Hours	Min.								
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Gardening</u>									
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Talbot County, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>									
<b>13. FATHER'S NAME</b> <u>Albert Wilson</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Henrietta Blake</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>222-20-3372</u>									
<b>17. INFORMANT</b> <u>Elsie Stanley, Cambridge, Md.</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Therapeutic misadventure with anesthesia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ruptured gall bladder with subdiaphragmatic abscess 10 days</u> DUE TO <u>and pleural effusion with compression of lungs</u> (c)									
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Expired on the operating table before exp. Laparotomy</u>									
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Expired on the operating table before exp. Laparotomy</u>		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> a. m. p. m.									
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)									
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
<b>ACTUAL SIGNATURE</b> <u>Louis M. Merty</u>		<b>DATE SIGNED</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
<b>EXAMINER'S NAME</b> (Type) <u>Louis M. Merty</u>		<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>									
<b>22b. DATE THEREOF</b> <u>2/3/1957</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Trappe Cemetery</u>									
<b>22d. LOCATION</b> (City, town, or county) (State) <u>Trappe, Maryland</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Walter M. Sellaire Jr.</u>									
<b>24a. REC'D BY REGISTRAR</b> <u>2/3/57</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>N. H. Nevers</u>									

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

FEB 19 1957

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